

CITY OF RIVERSIDE HEALTH BENEFITS ENROLLMENT/CHANGE FORM

Name of Subscriber: Last First M.I. Social Security No.				Birth Date: _____ Sex: Male Female		Indicate actions that apply: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> Medicare Plan <input type="checkbox"/> Cobra <input type="checkbox"/> Edit Name/Address <input type="checkbox"/> Student Status </div> <div style="width: 45%;"> <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Add Dependent <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change Medical Group <input type="checkbox"/> Change Primary Care Physician <input type="checkbox"/> Cancel Coverage Eff. _____ <input type="checkbox"/> Other _____ </div> </div>	
Address City State Zip				Marital Status (Circle One) <div style="display: flex; justify-content: space-around;"> Single Married Divorce </div>			
Department/Division Hire Date Work Phone Home Phone				Marriage/Divorce Date: _____			
Bargaining Unit Name City Employee ID Number							

Choose Your Health Plan/Type (Select One)				If dependent(s) have a different address, please indicate. <u>If you have a college age dependent this entire section must be completed.</u>																																					
<input type="checkbox"/> Kaiser Permanente/VSP # _____				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 15%;">Student/Dependent</th> <th style="width: 15%;">Name</th> <th style="width: 25%;">Address</th> <th style="width: 15%;">City</th> <th style="width: 10%;">State</th> <th style="width: 10%;">Zip</th> <th colspan="2"></th> </tr> <tr> <td colspan="8" style="height: 40px;"></td> </tr> <tr> <th>Name of Institution</th> <th></th> <th>Address</th> <th>City</th> <th>State</th> <th>Zip</th> <th># of Units</th> <th></th> </tr> <tr> <td colspan="8" style="height: 40px;"></td> </tr> </table>						Student/Dependent	Name	Address	City	State	Zip											Name of Institution		Address	City	State	Zip	# of Units									
Student/Dependent	Name	Address	City	State	Zip																																				
Name of Institution		Address	City	State	Zip	# of Units																																			
<input type="checkbox"/> Blue Cross (CaliforniaCare)/VSP # _____																																									
Choose Your Coverage Type (MUST SELECT AN OPTION)				Do any dependents have other health insurance? If yes, please complete:																																					
_____HMO High _____HMO Midway _____HMO Low				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Dependent's Name</td> <td style="width: 30%;">Insurance Company Name</td> <td style="width: 20%;">Policy No.</td> </tr> <tr> <td colspan="3" style="height: 40px;"></td> </tr> </table>						Dependent's Name	Insurance Company Name	Policy No.																													
Dependent's Name	Insurance Company Name	Policy No.																																							
_____BC PPO _____BC Out-of-State _____Medicare				If you are a Retiree and are over the age of 65, do you qualify for Medicare? (Please circle one) YES NO																																					

List Eligible Person(s) to be Covered OR Person(s) to be Deleted									
Relationship	Last Name	First	M.I.	Social Security No.	Birth Date	Age	*Medical Group/IPA #	Blue Cross HMO IPA Primary Care Physician Code	Existing Patient
<input type="checkbox"/> Self									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No

*Blue Cross HMO (CaliforniaCare) participants must select a Medical Group and Primary Care Physician and list name(s) and address exactly as it appears in the directory.

Enrollment Agreement and Payroll Deduction Authorization

I acknowledge that the above information represents my enrollment choice(s). I understand my coverage elections cannot be changed until a future benefits enrollment period. I represent that to the best of my knowledge and belief, all statements and answers made on this form are true and complete. If applicable, I authorize any insurance company, hospital, physician, or any other health care provider to release all information to all those who may have a bearing on benefits available under this plan. Adjustments may be made to increase or decrease the amounts specified for deductions by the City, provided that the method, manner and amount of such deductions are in full compliance with applicable laws and administrative rules and regulations of the City. The employee portion of the deduction will be automatically deducted pre-taxed on a biweekly basis (This excludes Domestic Partner participants). If I am adding a domestic partner, I will provide a copy of the "Declaration of Domestic Partnership" which can be provided by the Secretary of State, in order for my domestic partner to be eligible for benefits.

I have read and accept the arbitration and privacy information on the reverse side of this form. _____
 I understand and agree to the terms and conditions described on both sides of this form. **Initials**

Employee Signature _____ Date _____
 Original/Insurance Co. Yellow/Employer Pink/Employee



Important Information for Kaiser HMO Participants:

Some of the health plans offered by the City of Riverside, including Kaiser Foundation Health Plan, require resolution of medical malpractice and other disputes through binding arbitration. If you select one of these plans, you agree to give up your right to a jury or court trial for resolution of these disputes.

For additional information about each plan's arbitration provision, please refer to the Disclosure Form and Evidence of Coverage, copies of which are available from Human Resources.

Blue Cross of California:

ARBITRATION AGREEMENT: If your coverage is provided under an employer-sponsored plan subject to ERISA, certain disputes may not be subject to the Binding Arbitration provision.

Any dispute connected with a Blue Cross plan or an affiliate ("Blue Cross"), whether related to the agreement of or cancellation of care, or the relation to care or its delivery, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. By agreeing to arbitration, the member and Blue Cross acknowledge that they surrender their right to a court trial by jury and also agree to relinquish their right for class arbitration against each other. Arbitration findings will be final and binding unless California or Federal Law provides for the judicial review of the arbitration proceedings.